PRINTED: 01/22/2020 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING IL6005474 12/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 27TH STREET **BRIA OF BELLEVILLE BELLEVILLE, IL 62226** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S 000 S 000 Initial Comments Complaint Investigation 1948672/IL117825 S9999 S9999 Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

as free of accident hazards as possible. All

nursing personnel shall evaluate residents to see that each resident receives adequate supervision

a) An owner, licensee, administrator, employee or

TITLE

(X6) DATE 12/17/19

Electronically Signed

Attachment A

Statement of Licensure Violations

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and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

PRINTED: 01/22/2020 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING IL6005474 12/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 27TH STREET **BRIA OF BELLEVILLE BELLEVILLE, IL 62226** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 1 S9999 agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, record review and interview, the facility failed to provide supervision for a resident at risk for falls for 1 of 4 residents (R3) reviewed for falls the sample of 4. This failure resulted in R3 falling and sustaining a left hip fracture. Findings include: R3's Order Summary Report, dated 09/26/19, document diagnoses of Hemiplegia, Unspecified Affecting Left Nondominant Side and Nontraumatic Subarachnoid Hemorrhage. R3's Minimum Data Set (MDS) dated 10/04/19 documents that R3 is cognitively intact. R3's MDS dated 10/09/19 documents R3 was not steady, was only able to stabilize with staff assistance when moving on and off the toilet and has impairment on the upper and lower extremities on left side. R3's Care Plan, dated 10/09/19, documents, "(R3) requires assist with daily care needs rt (related to) hemiplegia (paralysis on left side of

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the body) and has reduced mobility. Assist resident with (Activities of Daily Living)."

R3's Fall risk assessment, dated 11/22/19, documents that R3 is at high risk for falls.

R3's Fall Report dated 11/09/19 at 6:54 AM documented, "I (V11/Certified Nursing

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Illinois Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ CB. WING 12/04/2019 IL6005474 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 150 NORTH 27TH STREET **BRIA OF BELLEVILLE BELLEVILLE, IL 62226** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 | Continued From page 2 Assistant/CNA) put (R3) on the toilet. I (V11) went to get her clothes and wash cloths to wash her up. As I, (V11) walked back towards (R3) in the bathroom, (R3) fell to the floor before I could reach her." On 11/27/19 at 9:30 am R3 stated, "I was by myself in the bathroom, I got dizzy and fell off the toilet. She (V11) wasn't gone long. I told her to get me up to my chair." R3 continued, "My back and my butt hurt. It's been hurting ever since." On 11/27/2109 at 1:00 pm V11 stated, "I went in to her (R3's) room, assisted her to get to the toilet. I went into her bedroom and got her (R3's) clothes off her bed. I came back into the bathroom and she was rocking back and forth and then she fell off the toilet." V11 continued. "I would not leave a resident alone if they are unsteady and I would make sure I have all the stuff I need to take care of them." On 11/27/19 at 9:45 am V7 (CNA) stated, "She (R3) can sit by herself, but we stay with her; it is a must. She can become unsteady. We always have done that even before her fall." On 12/02/19 at 12:07 pm V17 (Licensed Practical Nurse/LPN) stated, "She (R3) fell around 6:00 am on 11/09/19. She was lying on the floor next to the toilet. I did range of motion on her legs and arms; she denied pain. There was no bruising or open area." V17 continued that "she (R3) did not complain of being dizzy." On 12/02/19 V7, V15 (CNA), and V16 (CNA) all stated they would not leave a resident who was

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unsteady unattended on the toilet and before they would put a resident on the toilet, they would make sure they have all the equipment and

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ C B. WING 12/04/2019 IL6005474 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 150 NORTH 27TH STREET **BRIA OF BELLEVILLE** BELLEVILLE, IL 62226 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X4) ID COMPLETE. PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 3 supplies they need for care. On 11/27/19 at 2:07 pm V9 (Rehabilitation/Restorative Nurse) stated, "I would expect the CNAs to stay with a resident if they were unsteady." R3's Radiology Results Report, dated 11/18/19, documents "Impression left hip: Transcervical fracture of the left femoral neck with Varus deformity." R3's Emergency Room Visit Report, dated 11/18/2019, documents "The patient (R3) is a 52-year-old female who presents to ER (Emergency Room) for evaluation of left hip fracture. She reports that she fell from the toilet on November 9th and landed on her left hip. Since then she has been experiencing pain in the left hip." R3's Computed Topography (CT) Scan results, dated 11/19/19, documents, "Impacted left Subcapital femoral fracture. No evidence of pathologic fracture." On 12/02/19 at 11:50 am V4 (Regional Nurse/RN) stated that she would expect the staff to stay with a resident who is unsteady while sitting on the toilet and that it would be situational as to what supplies the staff may need during care. On 12/03/19 V19 (Nurse Practitioner/NP) for R3 documented, "Considering (R3) had no (history) of falls and (Physical Therapy and Occupational Therapy) had (evaluated) (R3), staff should assist with transfers and monitor as needed." (B)

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FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING: _____ B. WING _ IL6005474 12/04/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 27TH STREET **BRIA OF BELLEVILLE BELLEVILLE, IL 62226** (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)

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